

Psychedelic-assisted EMDR therapy (PsyA-EMDR): A memory consolidation approach to psychedelic healing

As access to psychedelic therapy is rolled out, there is a need to develop comprehensive preparation and integration protocols, particularly to support individuals with an impaired capacity to self-regulate. Moreover, there is an immediate need to develop comprehensive, trauma-informed harm reduction and risk minimisation models as illegal, underground psychedelic therapy rapidly expands. This article outlines a 12-session protocol for psychedelic-assisted eye movement desensitisation and reprocessing therapy (PsyA-EMDR), where the 8-phases are utilised to enhance the preparation and integration stages of this ground-breaking psychotherapeutic intervention. Because the memory consolidation model of EMDR is suited to support complex post-traumatic stress disorder (cPTSD), it is proposed that it would also work well in supporting those experiencing regressed ego states as well as the somatic dysregulation that is often caused during work with psychedelics. This trauma-informed framework focuses on stabilisation, resourcing, tolerance testing, and embodiment before individuals receive any psychedelic treatments.

Introduction

After years of restrictions on research into the healing properties of psychedelic substances, recent developments in the field have seen a second wave of trials take place. The pharmaceutical trials have now reached phase 3 in America and the UK (e.g. Mitchell, 2021; Gukasyan et al., 2022), where psychedelic treatments are being studied with large, clinical cohorts (300+ participants), in conjunction with psychotherapy in outpatient settings. Treatment protocols have naturally emerged

from the research because of the ethical requirement for a therapeutic container for the participants. These psychedelic-assisted therapeutic protocols have been developed to aid the integration of insights gained through the administration of psychedelic compounds and facilitate sustained positive change (Mithoefer et al., 2015; Watts & Luoma, 2020; Wolff et al., 2020; Brennan & Belser 2022). Rapid expansion of this field – in both research and underground – has highlighted a need for a trauma-informed approach to facilitate preparation and integration as well as harm reduction and risk minimisation. This article highlights some of the limitations within current psychedelic therapy protocols, specifically when treating clinical populations with complex post-traumatic stress disorder (cPTSD) and those with undiagnosed sensitivities. Furthermore, this article outlines why eye movement desensitisation and reprocessing (EMDR) therapy (Shapiro, 2001; 2018) is a potential candidate for psychedelic-assisted psychotherapy.

This forms part of a series of articles exploring how the 8 phases of EMDR therapy can be adapted to support individuals receiving psychedelic therapy.

The AIP model in the psychedelic space

The Adaptive Information Processing (AIP) framework was developed alongside EMDR therapy to conceptualise the pathogenesis of psychological issues and change (Shapiro, 2007; Hase et al., 2017). A central tenet of the framework is that maladaptively stored memories that are inadequately processed by the brain during periods of dysregulation, are the root cause of many psychological disorders (Scelles & Bulnes, 2021). The AIP model proposes that impairments to the information processing systems of the brain under stress cause memories to be stored in an unprocessed, state-specific form that is not connected to adaptive information such as a sense of safety in the present (Van der Kolk, 1989; Hamner et al., 1999; Hase et al., 2017).

A key reason for the combination of therapeutic interventions such as EMDR with psychedelic treatment is the neuroplasticity that they promote (Ly et al., 2018; Aleksandrova & Phillips, 2021). From an AIP perspective, these neuroplastogenic

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effects could facilitate the reprocessing and integration of emotionally salient material (Vollenweider & Preller, 2020) that is maladaptively stored in the memory networks through the use of EMDR therapy.

'Dissociation' of overwhelming experience from conscious awareness has been recognised as a psychological defence for over 120 years (Janet, 1901; Putnam, 1996; Schore, 2009). The resulting compartmentalisation of sensory material (Nijenhuis & van der Hart, 2011) can disrupt general functioning if it is re-activated by stressors in the present (Bourne et al., 2013). With this in mind, neuroimaging studies have shown that psychedelics fire up many pathways of the brain, creating connectivity that mimics that of an infant (Carhartt-Harris, 2016). From an AIP perspective, psychedelics facilitate the integration of dissociated memory networks as well as the maladaptively stored sensory material encoded within them. On a neurological level, this could explain the underlying mechanism for the integration of trauma whilst under the influence of psychedelics. During this time, subconscious psychological barriers are removed, enabling an individual to connect with the aforementioned sensory information (Carhartt-Harris et al., 2014).

In this concept lies a warning for individuals with complex trauma histories or individual sensitivities that have not been addressed in therapy prior to the administration of psychedelics. The dissociative barriers are there to keep the nervous system stable (Maldonado & Spiegel, 1991). There is a risk that individuals can become overwhelmed by the sudden reconnection with compartmentalised traumatic material that can cause lasting side-effects such as severe dissociation or heightened anxiety levels (Hopper et al., 2007; Halpern et al., 2018). The pathology 'hallucinogen persisting perception disorder' (HPPD, American Psychological Association, 2013) has been used to describe a non-psychotic disorder where an individual experiences visual hallucinations that persist after the use of any drug, including psychedelics. From an AIP perspective, this could be conceptualised as the reactivation of visual or somatic fragments of a maladaptively stored memory of a psychedelic experience, if the brain was sufficiently dysregulated whilst hallucinating.

Stanislav Grof coined the term 'holotropic state' to describe a non-ordinary state of consciousness, experienced on psychedelics or during meditation or breathwork (Grof, 2003). The term holotropic is derived from Greek and means 'moving in the direction of wholeness'. During re-processing the therapist sets up the conditions for the brain to naturally move towards wholeness through the implementation of bilateral stimulation (BLS). There is a similarity between the holotropic state elicited by psychedelics and the re-processing phase of EMDR because the dream-like state elicited during re-processing allows sensory material to naturally emerge in a manner that clearly delineates from the 'normal,' everyday realm of consciousness. This shift in subjective awareness, allows access to subconscious material which adheres to definitions of altered states of consciousness (Krippner, 1972; Stein et al., 2004). Winkelman's (2019) research into the neuroanthropology of consciousness defines four modes of consciousness – waking mode, deep sleep mode, REM sleep /dreaming mode and the integrative mode. He places psychedelics, hypnosis and meditation in the integrative mode but it is possible EMDR would traverse the REM mode because the eye-movements cause similar neural activations to saccades during REM sleep (Andrillon et al., 2015) and the integrative mode because of the way dissociated material emerges and is integrated using BLS. It is possible that the action of the bilateral stimulation of the brain in re-processing is partly responsible for this, and the working memory taxation model of EMDR goes some way to account for the brain gaining access to emotionally salient material during re-processing (van den Hout et al., 2011; 2014 Matthijssen et al., 2017). Bilateral stimulation of the brain also appears to facilitate free association and memory retrieval through interhemispheric connectivity (Bergmann, 1998; Yaggie et al., 2015), that mimics the interconnectivity seen in psychedelic studies, albeit at a lower level.

Critics of PsyA-EMDR have questioned the need for the use of psychedelics when EMDR therapy is such an effective intervention that adapts to many different psychological presentations. However, if we consider the example of cPTSD clients who have experienced severe abuse or neglect in childhood, there is often no embodied memory of safety and/or positive emotional connection (Siegel, 2020). Developing psychological resources with this client group can be difficult because

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there is very little adaptive information in the networks. This is where substances such as ‘empathogen’ 3,4-methylenedioxy-methamphetamine (MDMA) can be particularly useful, because as well as impacting fear extinction, emotional processing, and memory reconsolidation (Feduccia & Mithoefer, 2018) it elicits feelings of ‘love’ and ‘sociability’ (Bedi et al., 2010). This clear experience of embodied positive, interpersonal affect can then be explicitly strengthened as a psychological resource to utilise in later re-processing sessions. Developing this type of adaptive information is vital for clients with chronic, early attachment trauma.

Limitations of current protocols

Phase 3 psychedelic trials, where new treatments are compared with the best currently available treatment, have been conducted for MDMA (Mitchell, 2021) and approved for psilocybin (Compass, 2022). Research has moved on from dose tolerance, pharmacokinetics, and safety testing to large-scale, multi-site, international clinical treatment groups. Once an evidence base is formalised, these compounds will be prepared for market. After which, investigations commence into the implementation of various psychotherapeutic interventions to optimise the efficacy of psychedelic therapy. As yet, there is a dearth of literature available on the impact of the therapeutic input, and this needs to be addressed. The concept of ‘psychedelic-assisted therapy’ is key because psychedelics alone are not a silver bullet for psychological issues, as shown by recent ketamine trials where the participants depressive symptoms did not improve. These results may have been due to the lack of adjunct therapy as part of the protocol to address the underlying cause of their presentation (Atai Life Sciences, 2023).

In the context of clinical research, the number of integration phases offered differs depending on the ethics committee’s recommendations, the compound used, and the number of doses offered. Phase 2a (first trials in a clinical population) will require more therapy. For example, a trial offering two doses could involve the following (in this order):

- 1-hour recruitment telephone interview conducted by the recruitment team
- 1-hour psychiatric online pre-screen conducted by the therapy team
- 2-hour in-person screening with the study psychiatrist
- 1 x 3-hour preparation session with the therapy team
- A psychedelic treatment with the therapy team on day 0 and day 14
- Integration therapy on day 0, +1 (in person), +7, +15, +23 (online), and a follow up call on day +90 (with the therapy team).

The integration sessions generally consist of non-directive exploration of the psychedelic experience to facilitate emotional processing of the experience (Mithoefer et al., 2015). A goals-based approach is used to refer back to the participant's intention and consolidate the 'take-home' message from the experience that they want to integrate into their daily lives (Watts, 2021).

Despite research focusing heavily on psychedelic substances in the early phase trials, psychotherapeutic interventions and protocols have inevitably emerged from the research because a psychological container is required for the participants. Therapeutic input is minimal because a researcher's priority is to address the efficacy of the compound. In the UK, one of the main protocols that is being used on psilocybin trials is based on the 'Cognitive Flexibility Model' (CFM) (Hayes et al., 2006), the theoretical framework that underpins Acceptance and Commitment Therapy (ACT [Hayes, 2004]). This model has been augmented for use in the psychedelic healing space, using qualitative and quantitative data from ongoing trials to create the Acceptance, Connection & Embodiment model (ACE [Watts & Luoma, 2020]). CFM and ACT have a large evidence base (1000+ research papers as well as cognitive behavioural research from the wider field) and this possibly accounts for its use in these trials. However, as the field expands to more complex clinical populations, the gaps in the ACE model are becoming clear.

The ACE model focuses on cultivating the acceptance of difficult emotions and bodily sensations as they arise, and connecting to the meaning behind the feelings. This is achieved through a series of interventions designed to develop the three areas of acceptance, connection and embodiment. Embodiment is practiced during the

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preparation phase with a guided visualisation where participants are encouraged to 'let go and dive into their bodies' using a body scan. The diving metaphor is used to encourage the participant to go towards difficult emotions and look for the 'pearls of wisdom' from the difficult emotion, then set an intention for the following day based on this. A key point highlighted by Watts is that the ACE interventions are flexible and not prescriptive (Watts & Luoma, 2020; Watts, 2021).

Further research is being conducted to enhance the embodiment element of the ACE protocol, which currently consists of learning to sit with somatic responses as they arise during guided meditation. This is not comparable to the strong somatic responses that can emerge during a psychedelic treatment and does not adequately prepare the participants to navigate this.

The developing ACE model is currently lacking in a comprehensive somatic framework in the following areas:

- Adequately preparing the participant for experiencing bodily affect during the psychedelic phase.
- Developing the capacity and strategies to manage strong bodily affect and uncomfortable emotions.
- Developing an embodied set of psychological resources to support the participant during any dysregulation caused during the psychedelic therapy phase.
- Facilitating the integration of somatic and emotional material that may arise during the psychedelic phase.
- Stabilising participants who experience 'adverse events' (Instruments, 2004) during dosing.

Participants are thoroughly screened using a combination of their GP's medical records, questionnaires, and psychiatric interviews. Stringent exclusion criteria in early the phases of clinical research means that samples are not representative of the general population. Phase 3 trials are performed in a less homogeneous patient

population (with higher levels of risk) than phase 2 trials, to better reflect real-world results and so an increase in adverse events is expected.

During the ACE preparation phase, participants are asked about any biographical material that could emerge during the treatment which is then used as a mechanism to prepare participants for difficult material that may encounter, bringing it into their awareness. The non-directive ACE case conceptualisation is future focused and goal oriented (Watt & Luoma, 2020).

In contrast, the PsyA-EMDR protocol explicitly co-creates a case conceptualisation by exploring the relationship between presenting issues and their history using the AIP model and psychoeducation. . This information is then used to inform interventions throughout therapy, particularly the resourcing and stabilisation phases. Psychoeducation, through applying the AIP model to clients presenting issues, empowers them and develops metacognitive ability and the capacity to self-regulate. Understanding the AIP model also encourages the client to consider the salience of material that might emerge during their psychedelic therapy.

EMDR as an alternative psychedelic preparation and integration therapy

The AIP model posits that negative emotional and somatic responses are often the result of maladaptively stored memories in the brain (Hase et al., 2017). Therefore, the aim of the work in EMDR therapy is to release the somatic tension that is being triggered in the present, by targeting the corresponding maladaptively stored material with bilateral stimulation of the brain and in so doing eliminating the somatic response. The ACE concept of accepting and embodying the somatic response fails to address the maladaptively stored content. ACE seems to rely on exposure and then acceptance to support an individual's process. It is a passive approach to addressing pathological content. This works for many but is insufficient for those with more complex presentations. EMDR is well positioned to address this shortfall.

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Deactivation of the stress response and the resulting reduction of somatic symptoms are key aims of EMDR therapy, illustrated by the constant monitoring of the Subjective Units of Disturbance (SUD) (Wolpe & Lazarus, 1966) throughout the phases. If the ACE model is translated to participants who have been unable to fully integrate their psychedelic experience and suffer from symptoms of PTSD such as sustained dissociation or flashbacks, it is not adequately equipped to facilitate the integration of the traumatic memory responsible for the debilitating psychological and somatic intrusions in PTSD presentations.

It is clear that psychedelics cause a significant amount of dysregulation to the nervous system (Lerner et al., 2014) and the current preparation phases of the ACE protocol do not address this which is probably because the participants are stringently screened and deemed psychologically stable. A trauma-informed preparation phase, such as the resourcing, stabilisation, and preparation phases of AI-EMDR therapy (Shapiro, 2018; Parnell, 2013) could be developed to stabilise and prepare trauma clients for the dysregulation caused by re-processing, using BLS. This is particularly important for individuals with cPTSD who often had impaired attachment relationships in childhood that impact the development of their capacity to self-regulate (Schore, 2003).

Learning from the cPTSD population

Reactivation of maladaptively stored sensory material during a psychedelic experience poses the risk of flooding the nervous system, causing sustained psychological distress (Carbonaro et al., 2016). The cPTSD population should not automatically be screened from receiving psychedelic treatments, they may just require additional support in the preparation stages to develop their resources and affect regulation capacities. Attachment-informed EMDR is well equipped to do this, and an individual's tolerance to the dysregulation caused by memory work with BLS can also be used as an indicator of suitability for psychedelic therapy.

Re-processing traumatic memories with BLS of the brain, activates the nervous system and causes some degree of dysregulation. However, this can be stopped at any point to ground the client, unlike psychedelics that often have prolonged hallucinogenic effects. This is why the re-processing phase of EMDR therapy is an ideal 'test phase' in preparation for a psychedelic treatment. If the client is too dysregulated by this test phase, more time may need to be spent in the resourcing phase or they may be screened from psychedelic therapy completely.

The use of EMDR to treat psychotic clients is an example of how the AIP framework can be used to support unstable populations (Adams et al., 2020). The integrative nature of EMDR therapy makes it an ideal candidate to support the cPTSD population because it can easily be combined with other trauma-informed modalities such as Internal Family Systems (Schwartz, 1994). This combination is already widely used to treat severely dissociated clients, facilitating the integration of fragmented aspects of the psyche (Gonzalez et al., 2012). In the future, these adaptations of EMDR therapy for cPTSD will likely be a key part of supporting this population in the psychedelic healing space. Additional techniques such as Flash (Manfield et al., 2017) and EMDR 2.0 (Matthijssen et al., 2021) can also be utilised to facilitate integration with minimal activation of the nervous system.

Another issue with the current ACE protocol is the lack of pacing. This is an issue for those experiencing adverse reactions to psychedelics, or for those with more complex presentations. For some, embodied connection with psychedelic content, can cause flooding and be counter-therapeutic/retraumatising. The efficacy of current pacing in ACE is skewed because many of the trials screen out participants with complex trauma histories giving unrealistic populations. As testing becomes more inclusive, trauma-informed embodiment protocols need to be developed to support participants with experiences outside the limits of affect tolerance. PsyA-EMDR borrows tools that have been shown to be clinically effective when working with cPTSD presentations, allowing the pace of exposure to be slowed to tolerable levels and then worked with once stabilisation is achieved.

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The AIP model can be used to conceptualise the complexity of the client's trauma history as well as a general guide for the pacing of psychedelic work in the same way it is used in a standard trauma practice when treating cPTSD. Standardised trauma measures such as the Dissociative Experiences Scale (DES [Carlson & Putnam, 1993]) should play a role in this assessment.

Working with historic psychedelic content

The ACE model does not provide a framework for working with content from 'historic psychedelic experiences', defined by the authors as psychedelic content that has been non-responsive to other forms of integration treatment and still elicits affect for more than one year post psychedelics. The standard protocol from EMDR therapy can be used to integrate historic content that is unprocessed and causes reactivations (flashbacks), looping and blocking beliefs. EMDR can also be used as a tool to explore representative subconscious material to gain a deeper understanding of the self (Jung, 1951).

The somatic bridge

In psychedelic integration work using EMDR therapy, the somatic bridge (Watkins, 1971) is a key intervention to identify subconscious material that has emerged. It can be used in a similar way to working with dreams, whereby the image, cognition, feeling and sensation from a significant moment of the psychedelic experience can be bridged from, to identify the subconscious material they represent. Often this will be biographical trauma and childhood attachment experiences which can then be reprocessed using the standard protocol, with attachment-informed interventions if necessary. Sometimes more abstract material is bridged to, which can also be explored and reprocessed using BLS.

The transpersonal

One key impact of psychedelics is on the subjective experience of the self (Nour et al., 2016), that is characterised by increased feelings of ‘connectedness’ with others and one’s surroundings (Mason et al., 2020). This experience has been termed ‘ego dissolution’; the mystical experiences that occur during this process result from the disruption of boundaries between the self and the world (Nour & Carhartt-Harris, 2017). A dramatic shift in perception like this can be transformative for people who suffer from issues such as long-term depression, and studies have shown that psychedelic experiences that include a mystical experience have better therapeutic outcomes (Ko et al., 2022). The integrative nature of EMDR therapy means that it is possible to support transpersonal development through the use of interventions such as the intergeneration protocol (Brayne, 2019) and archetypal resource figures in the imaginal space (Parnell, 2013). The AIP framework is well aligned with key concepts in the field of psychedelics and Jungian Depth Psychology (Jung, 2014) in particular. Moreover, the AIP model and its conceptualisation of memory networks, mirrors that of Jung’s concept of ‘complexes’ (Jung, 1933) and Grof’s Systems of Condensed Experience (COEX) theory (Grof, 2009), two key figures in psychedelic research. The main difference is that Grof’s COEX systems expand further to perinatal stages and even to the transpersonal realm of past-lives (or more often, deaths). There is the potential to combine these theories to conceptualise the work through a transpersonal AIP lens, for example, when bridging somatically to abstract material. Intergeneration and attachment informed protocols may also be appropriate here.

Summary of the application of the 8 phases in PsyA-EMDR

Preparation for psychedelics (6 sessions)

Phase 1: History taking

The AIP model is used to create a case conceptualisation and develop a treatment plan. This is based on the complexity of the individual’s trauma history – which

determines the pace of the work and the amount of time spent in the preparation/resourcing phases; and also on the client's goals for therapy and more specifically for their psychedelic journey (also referred to as 'intentions' in psychedelic therapy). Psychoeducation is used to conceptualise the client's presenting symptoms in terms of the AIP model and applied to the psychedelic space to prepare them for what might emerge.

Phase 2: Resourcing

Resources are developed to explicitly prepare for the psychedelic space. Slight adaptations have been made to the traditional resourcing interventions, as follows:

- Preparing the client through psychoeducation about the psychedelic treatment and development of coping strategies.
- Physical objects can be chosen to represent the client's resources, in a similar way to the altar that is commonly used in the psychedelic space (Metzner, 1998). This is to have a tactile reminder of their team, peaceful place, and intention while potentially disoriented under the influence of psychedelics or phase 4 reprocessing.
- If the client is particularly anxious about the psychedelic journey, it can be beneficial to strengthen memories of courage by 'tapping in' memories of negotiating challenging situations.
- Psychoeducation around vagal mapping (Porges, 2011) can also be a helpful preparation tool for any dysregulation caused by psychedelics.

Intentions for the psychedelic experience are solidified in response to the client's goals for therapy and case conceptualisation. The 'wisdom figure' from the resource team can be utilised at this stage to explore their intention.

Phases 3-7: Reprocessing as psychedelic preparation

One or two sessions of reprocessing with BLS are used to assess the client's affect tolerance, develop their somatic awareness/mindfulness training, practice

embodiment through encouragement and coaching, develop dual attention skills, develop emotional literacy and finally explore metaphor/symbolic content – i.e., power animals/protector figures.

A target memory is selected to test the client's ability to tolerate strong affect when reprocessing and after the session has ended. Although this potentially causes milder dysregulation than the psychedelic phase, it is deemed a good assessment of the individual's readiness to proceed to this phase. This stage is particularly important for cPTSD clients who may require extra reprocessing sessions to stabilise the system adequately before considering the psychedelic phase.

It is suggested that the choice of target is oriented towards their intention or their connection with resources (or blocks preventing connection with resources). For those with high anxiety about the treatment, the flash forward protocol (Logie & De Jong, 2014) and then future template (Shapiro, 2018) can be used to target this.

At this stage, it is useful to work in an attachment focused manner and bridge back from the target to reprocess earlier biographical material because reparative attachment work can be done in the imaginal space to strengthen their sense of self (Parnell, 2013) and increase their capacity to self-regulate. They can also connect with their resource figures during re-scripting to strengthen the connection with them which may help with grounding in the psychedelic phase. Beginning to define/acknowledge needs that were missed during childhood can inform the choice of intention for psychedelic therapy.

Psychedelic therapy treatment phase

Currently in the UK, the only way individuals can access legal psychedelic therapy is via ongoing clinical trials or private ketamine treatment centres. People can also access legal treatments in countries such as Holland where the drugs laws are more relaxed. The quality of care offered across treatment centres varies dramatically and very few preparation and integration and phase 1 trials with 'healthy normal' volunteers offer therapy. This is also the case for the underground treatments on offer in the UK

where facilitators have very little training and are most often not trauma-informed in their interventions.

Post psychedelic treatment integration – 6 sessions

The post psychedelic therapy integration phase is where EMDR has the potential to work very effectively. The sensory material that has previously been experienced in the psychedelic space can be explored using techniques such as the somatic bridge to directly target the subconscious material that has emerged.

Phase 1: History taking

The client can talk through the whole journey with BLS on in the background and the therapist can note down any key themes, NCs/PCs, somatic and emotional responses that emerge. This information can then be added to the developing case conceptualisation.

Phase 2: Preparation

Any positive material from the journey can be strengthened with slow BLS and used as a resource. If it was a difficult journey, grounding and resourcing can be used here to stabilise before reprocessing.

Phase 3: Assessment of target

- Together, decide on an appropriate target from the psychedelic therapy phase based on their intentions/goals for therapy.
- Client to define the image, thought, feeling, sensation, NC and SUD linked to the chosen psychedelic material. Note: this can also include an underwhelming experience, 'lack of material', as well as the thoughts, feelings or physical sensations triggered by this.
- Use the somatic bridge into the memory network and identify the corresponding biographical target to reprocess. Client to define image, thought, feeling, sensation, NC and SUD of target ready to reprocess.

- Or, reprocess and rescript the material directly without bridging, as if it is a memory. Consider that this could be pre-verbal/perinatal or transpersonal material, and encourage radical acceptance of whatever emerges.

For very difficult experiences that have caused PTSD-type symptoms, discuss the use of Flash, EMDR 2.0, pendulation or similar to reduce the SUD to a low enough level to then bridge/re-process with the standard (AI informed) protocol.

When working with content from historic psychedelic use, the somatic bridge can be used from either the memory of the psychedelic experience or corresponding flashbacks/somatic material that is triggered in the present.

Phases 4, 5, 6: Desensitisation, installation, body scan

Activation and stimulation of target memory. Desensitisation and reprocessing. AI-EMDR informed re-scripting of memory and inner child work.

Phase 7: Closure

Ensure clients' stability in the session and between sessions through use of grounding visualisations such as the light stream or container.

Phase 8: Re-evaluation

In the following session, the historical target and the psychedelic journey can be re-evaluated to ensure that reprocessing is complete and that all the sensory information has been integrated. If there is still an emotional/somatic charge, the somatic bridge can be used to find other targets that may be blocking the reprocessing. The material is re-visited in subsequent sessions until the psychedelic material no longer holds negative emotional charge and is deemed fully processed/integrated. Additionally, the three-pronged approach is used to address past, present and future aspects of the clients' intentions moving forward.

Summary

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Psychedelics offer up a rich source of content from the deep psyche, and these expanded states seem to create optimum neurological conditions for the integration of trauma. As access to psychedelic therapy expands, both legitimately and in the underground scene, there is a distinct lack of suitable trauma-informed frameworks to adequately support the broad range of people engaging with these treatments.

Whilst suitable for many, the ACE model that is being developed in the UK is not adequately targeted or comprehensive enough to reliably prepare individuals for the dysregulation to the nervous system that can be caused during a psychedelic experience. EMDR therapy and its conceptual framework is proposed as a trauma-informed alternative to the current preparation and integration protocol, and elements could be translated for harm-reduction on the underground. The AIP model is well aligned with prominent theories from the field of psychedelics. Furthermore, its trauma-informed theory of memory consolidation is well placed to support participants with complex trauma histories.

Bridging techniques can be used to explore psychedelic content and access the memory matrix to re-process material from formative early years experiences, as well as intergenerational content and material from collective/cultural trauma. Adaptions to the standard protocol since its inception have broadened its application to areas such as the transpersonal, which is a common emergent theme from psychedelic therapy.

The AIP model of pathology, with its conceptualisation of memory encoding and meaning-making across a lifetime, is mirrored in key theories from psychedelic research. The similarities between the altered states of consciousness elicited by both psychedelics and bilateral stimulation of the brain are further indicators that EMDR is well aligned as an integration tool in psychedelic-assisted psychotherapy.

Limitations

The authors acknowledge that some of the assertions in this article are based on anecdotal evidence from their clinical work. However, this is currently the only way

that EMDR therapy is being investigated in the field of psychedelic research. We propose that this is a starting point for peer-reviewed research to commence.

Ideas for further research

- Incorporate EMDR protocols into clinical practice where possible.
- Empirical research into the use of reprocessing as a screening tool to identify more complex presentations that are not otherwise picked up during psychiatric assessments.
- Research into the development of affect tolerance through the use of EMDR in preparation for psychedelic therapy.
- Investigate the use of BLS during psychedelic therapy to counteract looping or chaining.
- Investigate EMDR therapy as a treatment for: HPPD, integrating historic psychedelic material, individuals experiencing adverse events as a consequence of dosing in a trial setting where other integration therapies have been ineffective.
- Use the principles of the AIP framework and the preparation phases of EMDR as a guide for training psychedelic therapists across modalities.

Conflict of interest statement

The authors have declared that no competing interests exist.

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